BES/Form 21
12/01

Utah Department of Health

To: Date:

Re:

Dr.

Please complete the information below regarding the condition of this patient and return it to the requesting agency in the envelope provided. Your prompt attention to this request is appreciated. We have attached a billing form which you can complete and return to the address on the form for payment.

Thank you,

Eligibility Worker

Release of Information

Dr., you are authorized to give the Department of Health or Department of Workforce Services the information requested below.

_____ _____ _____

Name of Patient Date Patient Signature

Does this patient's condition substantially reduce or eliminate the patient's ability to work or provide care for a child? ❝ Yes ❝ No

Date of Exam_____ Date of incapacity onset_____

Date incapacity will end _____ If unknown, date of next evaluation_____

Description of condition_____

Physician Comments: _____

_____

_____

Signature of Physician or Licensed/Certified Psychologist